Children's Mercy

Authorization for Release of Medical Information

8071-196 MR 09/20

Patient's Full Name and Previous Names Used | Date of Birth (__/__/__) | Medical Record Number

Street Address | City | State | Zip Code

DESCRIPTION OF INFORMATION TO BE DISCLOSED.

Information to be Released – Check all that apply:

- ☐ Pertinent Health Information (All clinical information for the last 2 years, includes radiology and laboratory reports, does not include images)
- ☐ Outpatient Clinic, Inpatient or ER visit for the following date or date range: _____
- ☐ History & Physical Only
- ☐ Visit List Only
- ☐ Immunization Records Only
- ☐ Other: Please list exact documents and/or date range needed:

_____

- ☐ Entire Health Record (Includes all electronic and paper documentation including non-clinical in the patient's record, does not include images, **charges may apply**)
- ☐ Images: (include date range requested)
  Radiology:_____ Cardiology: _____
  Neurology:_____ Other: _____
- ☐ Alcohol & Drug Information or HIV Test Results (circle one or both)

TO WHOM DISCLOSURE IS BEING MADE

Send Information to the Following – Please complete all fields:

Organization:	Telephone:
Attention:	Fax Number:
Email Address:	

Street Address | City | State | Zip

PURPOSE OF RELEASE

Purpose of Release – Check and complete all that apply:

- ☐ Doctor appointment on (date): __/__/__ Location: _____
- ☐ Other ongoing treatment or care: _____
- ☐ Other: _____

METHOD OF DISCLOSURE/RELEASE INFORMATION BY

Release information by:

- ☐ Mail delivery
- ☐ Pick up
- ☐ CD/DVD, if available
- ☐ Encrypted Email, if available size and restrictions apply
- ☐ Fax
- ☐ Verbal Communication
- ☐ Cloud Images
- ☐ Unencrypted Email if available size and restrictions apply. Signature required – see below

REVOCATION

I authorize the use and/or disclosure of the information specific in this authorization regarding the patient named above. I understand that I have the right to revoke this authorization at any time, except when actions have already been taken based on this authorization. To revoke this authorization, I must provide written notice to the Health Information Management department of The Children's Mercy Hospital or to the other organization named.

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Authorization for Release of Medical Information

8071-196 MR 02/23

EXPIRATION:
Unless this authorization is revoked, it will expire:
☐ Once the disclosure is complete
☐ Once the episode of care is complete

ASSURANCE OF PAYMENT: I do not need to sign a specific authorization to disclose information for treatment, payment or health care operations. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment, payment or eligibility for services at The Children's Mercy Hospital. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. If I have questions about disclosures of my information, I can contact the Health Management department of The Children's Mercy Hospital at (816) 234-3455.

Return completed form via fax to (816) 701-4034

Printed Name of Patient, Parent, or Legal Guardian	Relationship to Patient	( ) – Telephone Number
Signature of Patient, Parent, or Legal Guardian		/ / Date
Street Address (if different from above)	City / State	Zip Code

If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.

Individuals may request to receive their medical record and other protected health information (PHI), or direct the PHI to a third party, by alternative means, including without encryption. An unencrypted format is at risk for interception or access by an unintended person. Children's Mercy is not responsible for disclosure of PHI sent or stored in an unsecured manner at the individual's request, or for safeguarding the information once delivered.

Please sign below to request records in an unencrypted format. Your signature indicates that you understand and accept the risks of transmitting and storing PHI without encryption.

Printed Name of Patient, Parent, or Legal Guardian	Relationship to Patient	( ) – Telephone Number
Signature of Patient, Parent, or Legal Guardian		/ / Date

Staff Use Only

Released by_____ Date: _____

Return to HIM via fax 816-701-4034 or inter-office mail.

Copy to Individual.